Section 4: Managed Care Provider Information

Community Care of North Carolina—Carolina ACCESS

Community Care of North Carolina/Carolina ACCESS (CCNC/CA) is a primary care case management (PCCM) program that provides managed care for North Carolina's Medicaid recipients. Health care is coordinated and managed by primary care providers (PCPs) who contract with DMA. Enrollment in CCNC/CA is mandatory for the majority of Medicaid recipients but optional for others. PCPs receive a per-member, per-month management fee for providing and arranging for necessary health care of their enrollees.

Historically, North Carolina has had two PCCM programs. The initial program, Carolina ACCESS, created an infrastructure of PCPs. Community Care of North Carolina further developed this infrastructure into a network of community medical and service providers. CCNC/CA is used to identify managed care as a united program that provides access to high-quality primary care.

Carolina ACCESS

Initiated in 1991 as Medicaid's PCCM program, Carolina ACCESS was developed to provide Medicaid recipients with a medical home, which provides access to the public and private medical provider community. Enrolling recipients into a medical home reduces the need for recipients to seek primary care services and basic sick care services from hospital emergency departments. PCPs coordinate care for enrollees by providing and arranging care based on each enrollee's health care needs.

Participating Carolina ACCESS PCPs receive a monthly management fee of $1.00 per member per month for coordinating the care of Medicaid recipients enrolled with their practice(s). They also receive fee-for-service Medicaid reimbursement for the medical services provided to their patients.

Community Care of North Carolina—ACCESS II/III

Community Care of North Carolina, formerly known as ACCESS II/III, was initiated in 1996 as a community-based enhanced PCCM program, joining PCPs, hospitals, health departments, departments of social services (DSS), and other Medicaid providers into regional provider networks to manage the health care needs of Medicaid recipients. Each CCNC regional network employs care managers who assist in developing, implementing, and evaluating the care management strategies at each site. Care management strategies include

- Performing risk assessment—utilizing an "at-risk" screening tool that identifies both medical and social risk factors
- Reviewing emergency department utilization—integrating appropriate outreach, follow-up, and educational activities based on emergency department use by enrollees
- Implementing disease management processes—including, but not limited to, pediatric and adult asthma, congestive heart failure, and diabetes
- Implementing a care management process—identifying and targeting care management activities based on the screening process and other methods of identifying enrollees at risk
- Identifying high costs and high users—developing and implementing activities that lower utilization and cost

- Developing pharmacy initiatives to alleviate the high cost of medications

Currently, there are 14 CCNC regional networks that include more than 3,000 physicians across North Carolina. PCPs who affiliate with a network receive $2.50 per enrollee per month. Each CCNC network is governed by a local administrative entity, which is paid an additional $3.00 per enrollee per month to develop and implement care management strategies. CCNC is jointly administered by the Office of Rural and Community Care and DMA. The following is a list of the networks in CCNC:

ACCESSCare, Inc.
ACCESS II Care of Western North Carolina
ACCESS III of Lower Cape Fear
Carolina Collaborative Community Care
Carolina Community Health Partnership
Community Care of Wake/Johnston Counties
Community Care Partners of Greater Mecklenburg
Community Care Plan of Eastern Carolina
Community Health Partners
Northern Piedmont Community Care
Northwest Community Care Network
Partnership for Health Management
Sandhills Community Care Network
Southern Piedmont Community Care Plan

Recipient Enrollment

CCNC/CA is considered a higher level of benefit over regular Medicaid for recipients eligible to enroll. The county DSS is responsible for enrolling recipients Based on the Medicaid program aid category of eligibility, recipients are either required to enroll, optional for enrollment, or not eligible to be enrolled. Enrollment is mandatory for the majority of Medicaid recipients.

Medicaid recipients who enroll in CCNC/CA, whether as a requirement or an option, must select a medical home from the list of PCPs serving their county of residence. Recipients who do not choose a medical home may be assigned to a medical home by the county based on location, medical history, and other factors. Each family member may have a different medical home.

Enrollees may request to change their medical home at any time. The county DSS is responsible for processing an enrollee's change request. Changes are effective the first day of the month following the change in the system, pursuant to processing deadlines.

Enrollees are responsible for all copayments required by Medicaid. Refer to **Copayments** in **Section 2, Recipient Eligibility,** for additional information.

CCNC/CA enrollees are identified by information on their MID card. "Carolina ACCESS Enrollee" appears on the card, along with the name of the medical home, address, and daytime and after-hours telephone numbers.

Refer to **Verifying Eligibility** in **Section 2, Recipient Eligibility,** for information on verifying recipient eligibility.

Recipient Education

The county DSS is responsible for recipient education. Enrollees are provided with a Carolina ACCESS recipient handbook (available in English and Spanish) that informs them of the rights, responsibilities, and benefits of being a member. It is also important for PCPs, as the coordinators of care, to be actively involved in patient education. CCNC/CA PCPs are strongly encouraged to contact all new enrollees by telephone or in writing within 60 days of enrollment to schedule an appointment to establish a medical record for the new enrollee. New enrollees are identified in Section 1 of the monthly **Carolina ACCESS Provider Enrollment Report**. Refer to the examples of the reports at the end of this section.

Providers should inform each enrollee about the following:

- The availability of medical advice 24 hours a day, 7 days a week, and the preferred method for contacting the PCP
- The enrollee's responsibility to bring the current month's Medicaid identification (MID) card to each appointment
- The need to contact the PCP for a referral before going to any other doctor
- The need to contact the PCP before going to the emergency department, unless the enrollee feels that his or her life or health is in immediate danger
- The importance of regular preventative care visits, such as Health Check screenings for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings
- The availability of additional information for enrollees from the county DSS
- Copayment requirements

DMA's customer service center is available to help all Medicaid recipients understand their health care benefits. Customer service representatives also help enrolled recipients understand the procedures for obtaining health care in a managed care program.

Provider Participation

Requirements for Participation

DMA Managed Care and DMA Provider Services work together to recruit and enroll PCPs into the CCNC/CA program. DMA Provider Services is responsible for processing the applications and enrolling providers into the program. DMA Managed Care is responsible for establishing PCP participating requirements, assisting providers in carrying out CCNC/CA policies and procedures, and recruiting providers into the program. Questions about the CCNC/CA program or requirements for participation can be answered by the regional managed care consultants (see the list at the end of this section) or by the staff at DMA Managed Care (919-647-8170).

DMA requires providers to complete and submit a signed application and agreement confirming their compliance with all participation requirements. The **CA Provider Enrollment Packet** is available on DMA's website at http://www.ncdhhs.gov/dma/caenroll.htm. The application and the agreement must each contain the original signature of the authorized representative (or a participating provider). Applications may be pended for a maximum of 90 days from the date of receipt of the application by DMA Provider Services. Providers will be contacted if there are questions regarding information provided in the application. Providers are notified of their approval or denial in writing. Providers whose applications are denied may reapply at any time

unless a sanction has been imposed upon the provider's participation by the Managed Care Section.

Every DSS is notified weekly of new CCNC/CA providers and changes in current CCNC/CA provider information. Providers are required to report any changes regarding their practice's status to DMA Provider Services. To report changes to the Medicaid program, CCNC/CA providers must submit a signed **Medicaid Provider Change Form**.

To be approved as a CCNC/CA PCP, providers must meet the following requirements:

1. Accept N.C. Medicaid payment as payment in full, practice in the state of North Carolina or within 40 miles of the borders of North Carolina, and have an active N.C. Medicaid provider number (MPN) for use as the CCNC/CA provider number.

2. Have an active license for each provider in the practice. Each physician and doctor of osteopathy must also have an active individual MPN. Participating nurse practitioners and certified nurse midwives who have been issued individual MPNs must also disclose their individual provider numbers on the CCNC/CA provider application. The information on file for each individual MPN must be consistent with the information provided in the CCNC/CA application.

3. Be enrolled as one of the following Medicaid provider types:
   Family medicine practitioners
   Gynecologists
   General practitioners
   Internists
   Nurse practitioners
   Federally qualified health centers
   Osteopaths
   Health departments
   Pediatricians
   Rural health clinics
   Obstetricians

   Note: Physician assistants do not directly enroll in Medicaid at this time, but may participate in Carolina ACCESS through their supervising physician and enroll with Carolina ACCESS using the supervising physician's MPN.

4. Enroll each CCNC/CA location with a separate, site-specific provider number. Practices operating as a group must enroll with a site-specific group number; solo practitioners may use their individual provider identification number or enroll with a group number if they are operating as a group. The name, address, and daytime telephone number must be consistent with the information reported to the N.C. Medicaid program, and must therefore be site specific. The CCNC/CA PCP's practice name, address, and daytime and after-hours telephone numbers are printed on the enrollee's MID card.

5. Enroll with CCNC/CA using a group number, if applicable, for ease of claims filing, referrals, management of reports, and accurate financial reporting to the IRS.

6. State on the initial application the maximum number of enrollees that will be accepted for the site and also any specific enrollment restrictions such as age or gender. Enrollment of Medicaid recipients is capped at 2,000 per participating provider (MD, DO, PA, NP, or CNM).

   Note: Providers who do not accept Medicare will not have CCNC/CA enrollees who have Medicare coverage assigned to their practice.

7. List on the application all contiguous counties from which the practice will accept CCNC/CA enrollees. Since the provider must be accessible for primary care, these counties must include only the county in which the practice is located and the bordering counties.

8. Disclose on the application information regarding sanctions or termination by the Medicaid program or the Carolina ACCESS program. For complete information, refer to **Sanctions** in this section.

9. Establish and maintain hospital admitting privileges or enter into a formal agreement with another physician or group practice for the management of inpatient hospital admissions of CCNC/CA enrollees. If the CCNC/CA practice does not admit patients and provide age-appropriate inpatient hospital care at a hospital that participates with the N.C. Medicaid program, then the **Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement** (on DMA's website at http://www.ncdhhs.gov/dma/formsca.html) must be submitted to DMA Provider Services to address this requirement for participation.

10. Have a provider available at each practice site to see scheduled and non-scheduled patients a minimum of 30 hours per week.

11. Provide access to medical advice and care for enrolled recipients 24 hours a day, 7 days a week. Refer to **24-Hour Coverage** in this section.

12. Make oral interpretation services available free of charge to each current and potential enrollee. This applies to all non-English languages.

13. Make primary care services available to enrollees and indicate these services on the application. These services must encompass all requirements for the specified ages. For example, a provider who wishes to enroll recipients ages 2 through 20 must agree to provide all components for each age category, 2 through 20.

    Note: PCPs who request CCNC/CA participation for enrollees with Medicaid for Pregnant Women (MPW) benefits only are exempt from the preventive and ancillary services requirements.

Conditions of Participation

When a provider agrees to participate with CCNC/CA, she or he agrees to

- Develop patient–physician relationships
- Manage the health care needs of recipients
- Provide mandatory preventive services
- Authorize and arrange referrals, when necessary, for health services that the primary care practice does not provide
- Review and use recipient utilization, emergency room enrollment, and referral reports
- Follow standards of appointment availability

In addition to the conditions of participation for Medicaid providers (in **Section 3, Medicaid Provider Information**), CCNC/CA providers must comply with section 1932 (b)(7) of the Social Security Act, which states, "the Plan shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable State law solely on the basis of provider's license or certification."

Exceptions

Exceptions to a requirement for participation may be granted in cases in which it is determined that the benefits of a provider's participation outweigh the provider's inability to comply with this requirement. The provider shall submit a written request to DMA for consideration for exception for a specific agreement requirement. The request shall include the reasons for the contractor's inability to comply with this agreement. The request shall be submitted at the time this agreement is submitted to the DMA Managed Care Program Operations Manager for consideration. Approval of the application constitutes acceptance of the request for exception.

Sanctions

Failure to meet the terms outlined in the CCNC/CA provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly management/coordination fee may be withheld.
- The PCP may be referred to DMA Program Integrity (PI) for investigation of potential fraud or for quality-of-care issues.
- The PCP may be referred to the N.C. Medical Board.
- The PCP may be terminated from the CCNC/CA program.

DMA makes the determination to initiate sanctions against the PCP and may impose one or more sanctions simultaneously based on the severity of the contract violation. DMA may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered; or DMA may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit DMA from exercising its right to do so for subsequent contract violations.

Sanction Appeals

The PCP is notified by certified mail of the sanction and the right to appeal the sanction.

DMA must receive the PCP's request for a formal evidentiary hearing by the DMA Hearing Unit no later than 15 calendar days after the receipt of the sanction notice. The hearing provides an opportunity for all sides to be heard in an effort to resolve the issue. The sanctioned party may represent himself or herself, may designate a representative, or may enlist the services of an attorney. The findings are documented by the DMA hearing office and presented to the DMA Director, who makes the final determination to uphold or rescind the sanction. The PCP is notified by certified mail of the Director's decision.

PCPs who are terminated from the CCNC/CA program—or who voluntarily withdraw to avoid a sanction—are not eligible to reapply for a minimum of one year, with a maximum time period to be determined by the Managed Care Section. The decision is predicated on the extent or severity of the contract violation necessitating the termination.

Terminations

The PCP's agreement to participate in the CCNC/CA program may be terminated by either the PCP or DMA, with cause, or by mutual consent, upon at least 30 days' written notice delivered by registered mail, return receipt requested. Termination will be effective on the first day of the month, pursuant to processing deadlines.

Provider Reports

The goals of the CCNC/CA program are to improve access to primary care and to provide a more effective and cost-efficient health care system. It is the responsibility of PCPs to manage the care of their enrollees. DMA provides four reports to assist PCPs with this goal. An example of each report is available at the end of this section.

Enrollment Report

DMA's Managed Care Section provides PCPs with a monthly **CA Provider Enrollment Report.** The report consists of three sections for both Carolina ACCESS enrollees and N.C. Health Choice enrollees, if applicable: new enrollees, current enrollees, and terminated enrollees. It is the PCP's responsibility to review this report every month and report any errors to the managed care consultant or the county DSS. PCPs must continue to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported, until the change or error has been resolved and reported correctly. Refer to the end of this section for an example of the report.

Emergency Room Management Report

The **Emergency Room Management Report** lists the PCP's enrollees for whom emergency department services were paid during the month. It is very important to review this report to determine enrollees who are using the emergency department inappropriately and to develop strategies to redirect these enrollees to the appropriate setting. PCPs may need to evaluate their after-hours message or procedures or collaborate with an urgent care center to provide the most cost-effective after-hours care. Refer to the end of this section for an example of the report.

Referral Report

DMA provides CCNC/CA PCPs with a monthly **Referral Report** containing information on where and when enrollees obtained services during the month. The report is available to PCPs on paper or diskette. Refer to the end of this section for an example of the report.

Quarterly Utilization Report

The **Quarterly Utilization Report** provides a detailed representation of the utilization of services by enrollees linked to the PCP's practice. The report is based on claims paid for dates of service for the report quarter and assists the PCP in developing strategies for more cost-effective primary care. An example of the report and instructions for using it are available at the end of this section.

Provider Requirements

Health Check Services

CCNC/CA PCPs are required to provide Health Check preventive care screenings to Medicaid-eligible children aged birth through 20 years. PCPs serving this population who do not provide Health Check screenings are required to pursue an agreement with the local health department to provide all Health Check screening components. PCPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services. Refer to DMA's website at http://www.ncdhhs.gov/dma/formsca.html for a copy of the **Health Check Agreement between Primary Care Provider and the Local Health Department.**

Refer to the *Health Check Billing Guide* on DMA's website at
http://www.ncdhhs.gov/dma/healthcheck.htm for additional information.

Adult Preventive Annual Health Assessments

CCNC/CA PCPs are required to provide all of the components of an initial preventive annual
health assessment and periodic assessments to adult enrollees aged 21 years and over. For more
information, please refer to the latest edition of the *Pocket Guide to Clinical Preventive Services,*
from the U.S. Preventive Services Task Force, at http://www.ahrq.gov/clinic/uspstfix.htm.

24-Hour Coverage

CCNC/CA requires PCPs to provide access to medical advice and care for enrolled recipients 24
hours a day, 7 days a week. There must be prompt (within 1 hour) access to a qualified medical
practitioner who is able to provide medical advice, consultation, and authorization for service
when appropriate. PCPs must have at least one telephone line that is answered by the office staff
during regular office hours.

PCPs must provide enrollees with an after-hours telephone number. The after-hours number may
be the PCP's home telephone number. The after-hours telephone line must be listed on the
enrollee's MID card. The after-hours telephone number must connect the enrollee to one of the
following:

- An answering service that promptly contacts the PCP or the PCP-authorized medical
  practitioner
- A recording that directs the caller to another number to reach the PCP or the PCP-
  authorized medical practitioner
- A system that automatically transfers the call to another telephone line that is answered
  by a person who will promptly contact the PCP or PCP-authorized medical practitioner
- A call center system

A hospital may be used for the 24-hour telephone coverage requirement under the following
conditions:

- The 24-hour access line is not answered by the emergency department staff.
- The PCP establishes a communication and reporting system with the hospital.
- The PCP reviews results of all hospital-authorized services.

An office telephone line that is not answered after hours, or is answered after hours by a recorded
message instructing enrollees to call back during office hours or to go to the emergency
department for care, is **not acceptable.** It is **not acceptable** to refer enrollees to the PCP's home
telephone if there is no system in place as outlined above to respond to calls. PCPs are
encouraged to refer patients with urgent medical problems to an urgent care center.

Standards of Appointment Availability

PCPs must conform to the following standards for appointment availability:

- Emergency care—immediately upon presentation or notification
- Urgent care—within 24 hours of presentation or notification
- Routine sick care—within 3 days of presentation or notification
- Routine well care—within 90 days of presentation or notification (15 days if recipient is
  pregnant)

Emergency Conditions

An emergency medical condition is one in which the sudden onset of a medical condition, including emergency labor and delivery, manifests itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in

- serious jeopardy to the health of the individual or the health of a pregnant woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any body organ or part.

With regard to pregnant women having contractions, a situation is considered to be an emergency if

- there is inadequate time to effect a safe transfer to another hospital before delivery; or
- transfer may pose a threat to the health or safety of the woman or the unborn child.

Urgent Conditions

An urgent medical condition is defined as a condition that, without medical attention and intervention within 12 to 24 hours, could seriously compromise the patient's condition and the possibility of a full recovery.

Standards for Office Wait Times

PCPs must conform to the following standards for office wait times:

- Walk-ins—within 2 hours, or schedule an appointment within the standards of appointment availability
- Scheduled appointment—within 1 hour
- Life-threatening emergency—must be managed immediately

Hospital Admitting Privileges

CCNC/CA PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of CCNC/CA enrollees. An appropriate arrangement must be made to ensure access to care for all enrollees regardless of age. The **Carolina ACCESS Hospital Admitting Agreement/Formal Arrangement** fulfills this requirement for participation. It is a voluntary written agreement between the CCNC/CA PCP and the physician/group who is agreeing to accept the responsibility for admitting and coordinating medical care for the enrollee on behalf of the CCNC/CA PCP throughout the enrollee's inpatient stay. **This agreement must be completed by both parties.** The CCNC/CA PCP must submit the original form with his or her application for participation or when a change occurs regarding the provider's admitting agreement. A copy of the admission agreement on DMA's website at http://www.ncdhhs.gov/dma/formsca.html.

The following arrangements are acceptable:

- A formal agreement may be made with a physician, a group practice, a hospital group, or a physician call group.
- The physician, group practice, or hospital group need not be a CCNC/CA provider, but must be enrolled with the N.C. Medicaid program.

- Admitting privileges or formal arrangements must be maintained at a hospital that is within 30 miles or 45 minutes' drive time from the PCP's office. If there is no hospital that meets these geographic criteria, the closest hospital to the CCNC/CA PCP practice is acceptable.

Hospital admitting agreements with unassigned call doctors are unacceptable.

Exceptions may be granted in cases in which it is determined the benefits of a PCP's participation outweighs his or her inability to comply with the admitting privileges requirement.

Women, Infants, Children Special Supplemental Nutrition Program Referrals

Federal law mandates coordination between Medicaid managed care programs and the Women, Infants, Children (WIC) program. CCNC/CA PCPs are required to refer potentially eligible enrollees to the WIC program. Copies of the **WIC Exchange of Information Form for Women**, the **WIC Exchange of Information Form for Infants and Children**, and the **Medical Record Release for WIC Referral form** are available on DMA's website at http://www.ncdhhs.gov/dma/formsca.html.

For more information, contact the local WIC agency at the county DSS or the Division of Maternal and Child Health at 1-800-FOR-BABY (1-800-367-2229).

Transfer of Medical Records

CCNC/CA PCPs must transfer the enrollee's medical record to the receiving provider upon the change of PCP and as authorized by enrollee within 30 days of the date of the request.

Medical Records Guidelines

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. In order to promote quality and continuity of care, a guideline for medical record keeping has been established by the CCNC/CA program and approved by the Physician Advisory Group. All CCNC/CA PCPs must implement the following guidelines as the standards for medical record keeping.

These guidelines are intended for CCNC/CA PCPs. See **Section 3, Medicaid Provider Information,** for medical records standards that apply to all providers.

It is expected that the medical record should include the following whenever possible for the benefit of the patient and the physician:

1. Each page or electronic file in the record contains the patient's name or patient's Medicaid identification number and the office/practice from whom the page is coming.
2. All entries are dated.
3. The authors of all entries are identified.
4. The record is legible to someone other than the writer.
5. Medication allergies and adverse reactions, as well as the absence of allergies, are prominently noted and easily identifiable.
6. The patient's personal and biographical data— including age, sex, address, employer, home and work telephone numbers, and marital status—is recorded.

7. Medical history, including serious accidents, operations, and illnesses, is easily identified. For children, medical history includes prenatal care and birth.

8. There is a completed immunization record. For pediatric patients (age 12 and under) there is a complete record with dates of immunization and administration.

9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded.

10. Patients aged 12 years and over are asked about smoking, alcohol, and other substance abuse at the routine visit and their answers are recorded.

11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Records of consultation and significantly abnormal labs and imaging results have an explicit notation of the follow-up plans.

12. Emergency care is documented in the record.

13. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the patient is enrolled with CCNC/CA.

14. Documentation of individual encounters provides adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test(s), therapies, and other prescribed regimen(s); follow-up care, referrals, and results thereof; and all other aspects of patient care, including ancillary services.

Referrals and Authorizations

Coordination of care is a required component of CCNC/CA. PCPs are contractually required to provide services or authorize another provider to treat the enrollee. A referral from the PCP to another provider should be considered even when an enrollee has failed to establish a medical record with the PCP when medically necessary health care services are needed. In some cases, the PCP may choose to authorize a service retroactively. Some services do not require authorization. (Refer to the list of **Exempt Services** in this section.) All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. Referral of an enrollee to a specialist may be made by telephone or in writing. The referral must include the number of visits being authorized and the extent of the diagnostic evaluation.

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number is used for each treatment visit. It is the PCP's responsibility to provide any further diagnosis, evaluation, or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to treat an enrollee and then needs to refer the enrollee to a second specialist for the same diagnosis, the enrollee's PCP must be contacted for authorization. The same authorization referral number must be used by both specialists.

Authorization is not required for services provided in an urgent care center billing with a hospital provider number. Referrals to a specialist for follow-up care after discharge from an urgent care center **do** require PCP authorization.

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. **The physician component for inpatient services does require authorization.** Referrals to a specialist for follow-up care after discharge from a hospital also require PCP authorization.

In addition to CCNC/CA authorization, prior approval (PA) may be required to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of services. Refer to **Section 6, Prior Approval,** for additional information about services requiring PA.

Referrals for a Second Opinion

CCNC/CA PCPs are required to refer an enrollee for a second opinion at the request of the enrollee when surgery is recommended.

Referral Documentation

All referrals must be documented in the enrollee's medical record. PCPs should review the monthly **Referral Report** to ensure that services rendered to their enrollees were authorized and have been documented and recorded accurately in each enrollee's medical record. It is the PCP's responsibility to review the Referral Report for validity and accuracy and to report inappropriate referrals to the Managed Care Consultant. Refer to page 4-24 for an example of the report.

Submitting Referral Claims

Claims submitted for reimbursement of a service authorized by a recipient's Carolina ACCESS PCP must include the PCP's referral authorization number. Prior to the implementation of NPIs, this referral authorization number was the PCP's Carolina ACCESS provider number. With the implementation of NPIs, the PCP's NPI number must now be used as the referral authorization number. Carolina ACCESS PCPs must provide their NPI when authorizing a service. Claims must be submitted with the Carolina ACCESS PCP's NPI number (unless the PCP is atypical) as the referral authorization number or the claim will be denied.

When billing for a service authorized by a recipient's Carolina ACCESS PCP, providers must include the PCP's NPI as the referral authorization number on the claim. It is recommended that the provider also include the PCP's Carolina ACCESS provider number on the claim. A taxonomy is not required for the referral authorization NPI.

Refer to **Section 5, Submitting Claims to Medicaid,** for timeframes and requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides, and referring provider information on a claim.

Exempt Services

Enrollees may obtain the following services from Medicaid providers without first obtaining authorization from their PCPs:

- Ambulance services
- At-risk case management
- Child care coordination
- Community Alternatives Program services
- Dental care

  Note: CCNC/CA enrollees are instructed to contact their PCP for assistance in locating a dental provider enrolled with the Medicaid program. A list of dental providers is available on DMA's website at http://www.ncdhhs.gov/dma/dental/dentalprov.htm. Recipients can also be referred to the Office of Citizen Services, CARE-LINE Information and Referral, at 1-800-662-7030 or 919-855-4400 (English and Spanish).

- Developmental evaluations
- Eye care services [limited to CPT codes 92002, 92004, 92012, and 92014 and diagnosis codes related to conjunctivitis (370.3, 370.4, 372.0, 372.1, 372.2, and 372.3)]
- Family planning (including Norplant)
- Health department services
- Hearing aids (for recipients under the age of 21)
- HIV case management
- Hospice
- Independent and hospital lab services
- Maternity care coordination
- Optical supplies/visual aids
- Pathology services
- Pharmacy
- Radiology (only services billed under a radiologist provider number)
- Services provided by a certified nurse anesthetist
- Services performed in a psychiatric hospitals and psychiatric facilities (but see notes below)
- Services provided by schools and programs
- Outpatient behavioral health services for adult recipients (aged 21 years and older) when performed by direct-enrolled providers.

Note: Psychiatric Services – ICD-9-CM diagnosis codes 290 through 319.99 are exempt for all providers except local management entities and psychiatrists. Local management entities and psychiatrist providers must adhere to Medicaid's service-specific policies (http://www.ncdhhs.gov/dma/mp/mpindex.htm).

Outpatient psychiatric services can be referred for children under the age of 21 by a Medicaid-enrolled psychiatrist, the local management entity, or the PCP.

Although enrollees are not required to obtain authorizations from their PCPs for the services listed above, PA may be required to verify medical necessity before rendering some services. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. To determine if a procedure requires PA, call the Automated Voice Response (AVR) system at 1-800-723-4337. Refer to **Section 6, Prior Approval,** for information on services requiring PA.

Override Requests

It is the provider's responsibility to obtain authorization for treatment from the PCP listed on the enrollee's MID card prior to treatment. When services have been rendered to a CCNC/CA enrollee without first obtaining authorization from the PCP and the PCP refuses to authorize retroactively, providers may request an override using the **Carolina ACCESS Override Request form** to obtain payment. Override requests will be considered only for extenuating circumstances beyond the control of the responsible parties that affected access to medical care. Overrides will not be given for mental health services.

Override requests must be submitted to EDS within 6 months of the date of service. Requests will be evaluated within 30 days of receipt. A copy of the **Carolina ACCESS Override Request form** is on DMA's website at http://www.ncdhhs.gov/dma/formsca.html.

Medical Exemption Requests

CCNC/CA was established on the premise that patient care is best served by care coordinated through a PCP. Enrollees may request a medical exemption from participation in CCNC/CA. Depending on the condition of the patient, the exemption may be made for a 6-month period or for the lifetime of the patient. Exemptions are granted for the following medical conditions:

- Terminal illness—the enrollee has a life expectancy of 6 months or less or is currently a hospice patient

- Major organ transplant—this would be considered for a permanent exemption

- Chemotherapy or radiation treatment—the enrollee is currently undergoing treatment

    Note: This is a temporary exemption that ends when the course of treatment is completed. If the therapy will last for more than 6 months, the exemption must be requested after the initial 6-month time period during reapplication for Medicaid coverage.

- Diagnosis/Other—an enrollee may be granted an exemption if there is a specific diagnosis or other reason that the enrollee would not benefit from coordinated care through a PCP

    Note: Supporting medical record documentation for this category may be requested for review prior to a determination decision.

- End-stage renal disease

The **Carolina ACCESS Medical Exemption Request form** must be completed by the enrollee's physician and mailed to the DMA Managed Care Section at the address listed on the form. Recipients may also obtain the Medical Exemption Request form at their county DSS. A copy of the form is also available on DMA's website at http://www.ncdhhs.gov/dma.formsca.html.

Patient Disenrollment

On occasion, it may be necessary to disenroll a CCNC/CA enrollee from a practice for good cause.* To disenroll a patient, PCPs must follow these procedures:

- Notify the CCNC/CA enrollee in writing of the disenrollment. Specify the reason for disenrollment in the letter. Provide 30 days' notice. Advise the enrollee to contact his or her caseworker or the Medicaid supervisor at the county DSS to choose a new PCP.

- Fax a copy of the disenrollment letter to the Carolina ACCESS Coordinator at the county DSS. In addition, a copy of the letter should be sent to the Regional Managed Care Consultant. (PCPs can check with the Managed Care Consultant to confirm the correct Carolina ACCESS Coordinator at the county DSS).

Note: Until a county DSS worker deletes the PCP's name, address, and telephone number from the recipient's MID card, the PCP must continue to provide services to the enrollee or authorize another provider to treat the enrollee.

*Good cause is defined as follows:

- Behavior on the part of the recipient that is disruptive, unruly, abusive, or uncooperative to the extent that the provider's ability to serve the recipient or other affected recipients is seriously impaired

- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment

- Fraudulent use of the MID card

Additionally, a CCNC/CA enrollee may be disenrolled for nonpayment of copayments or an outstanding balance if this is a standard operating procedure for the practice, it is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

Carolina ACCESS—Frequently Asked Questions

1. **Is there a limit to the number of Carolina ACCESS patients that I can enroll for my practice?**
PCPs may enroll up to a maximum of 2,000 CCNC/CA enrollees per physician or physician extender, unless otherwise approved by DMA.

2. **Can I change my enrollment limit?**
PCPs may change enrollment limits or restrictions by completing and submitting a **Medicaid Provider Change Form**.

3. **How can I verify that a patient is enrolled with Carolina ACCESS?**
It is important to check the enrollee's current monthly MID card at each visit because the enrollee's eligibility status or medical home may have changed. If the patient is enrolled in CCNC/CA, the MID card will list the name of the medical home. If there is no medical home listed on the MID card, the patient is not currently in CCNC/CA.

   In addition to the verification methods listed in **Section 2, Recipient Eligibility,** enrollment can also be verified by

   - Calling the AVR system
   - Checking the current Carolina ACCESS Enrollment Report

4. **What should I do if the patient does not bring his or her MID card to an appointment?**
Verify the patient's enrollment by one of the methods listed in **Section 2, Recipient Eligibility,** or check the current Carolina ACCESS Enrollment Report. Alternatively, prior to rendering the service, the provider must inform the patient either orally or in writing that the service will not be billed to Medicaid and will, therefore, be the financial responsibility of the patient.

5. **What if the medical home listed on the patient's MID card is incorrect?**
Advise the patient to contact his or her caseworker or the Medicaid supervisor at the county DSS to request a change to another medical home. In most circumstances, the change takes a minimum of 30 days. Changes are typically effective the first day of the month following the change.

6. **Are Carolina ACCESS enrollees responsible for copayments?**
CCNC/CA enrollees are subject to the same copayment requirements as fee-for-service Medicaid recipients. Refer to **Copayments** in **Section 2, Recipient Eligibility,** for additional information.

7. **Do all Medicaid-covered services require authorization from the primary care provider?**
No. Some Medicaid-covered services are exempt from PCP authorization. See **Exempt Services** in this section.

8. **What if a Carolina ACCESS enrollee assigned to my practice needs health care that my office cannot provide?**
   PCPs are responsible for coordinating the care of enrollees and are therefore responsible for authorizing services as needed to specialists or other health care providers. Refer to **Carolina ACCESS Referrals and Authorizations** in this section for additional information on coordination of care.

9. **What is the process for referring a patient to a specialist or to other health services**?

   A CCNC/CA enrollee may be referred to any specialist or to other health services enrolled with Medicaid. Your NPI number must be provided to the specialist or other health service provider as the authorization number. Referrals may be made by telephone or in writing and must include the number of visits being authorized and the extent of the diagnostic evaluation.

10. **What if my PCP practice receives a request for an authorization for a patient we have not seen yet?**
    Because PCPs are contractually required to provide services or authorize another provider to treat the enrollee, PCPs are not required to authorize a specialist or another health service provider to treat an enrollee who has not yet been seen in their practice. However, if the PCP does not authorize treatment, an appointment must be made available to the enrollee according to the standards of appointment availability. All referrals must be documented in the enrollee's medical record.

11. **What if a Carolina ACCESS enrollee self-refers to our practice?**
    PCP authorization must be obtained before a CCNC/CA enrollee may see a specialist or another health service provider, unless the service is exempt from authorization. You may contact the PCP listed on the enrollee's MID card and request authorization, but the PCP is not obligated to authorize the service.

    If you do not receive authorization to treat the patient, you may refer the patient back to the PCP or inform the patient either orally or in writing, prior to rendering the service, that the service will not be billed to Medicaid and will, therefore, be the financial responsibility of the patient.

12. **Do Carolina ACCESS enrollees admitted through the emergency department require authorization from their primary care providers?**
    Referrals are not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services does require authorization.** Specialist referrals for follow-up care after discharge from a hospital also require PCP authorization.

13. **How should claims be filed when a PCP refers a Carolina ACCESS enrollee to our office?**

    Refer to **Section 5, Submitting Claims to Medicaid,** for timeframes and requirements for recording Carolina ACCESS PCP numbers, Carolina ACCESS overrides, and referring provider information on a claim.

14. **Whom do I contact if I have questions or require additional information?**
    DMA has established regional managed care consultants to assist managed care providers. Refer to the last page of this section for a list of consultants. If you are unable to reach the consultant, you may contact the DMA Managed Care program at 919-647-8170.

Modified Sample of Carolina ACCESS Provider Enrollment Report, Section 1, New Enrollees

CA PROVIDER ENROLLMENT REPORT

SECTION 1
"New Enrollees"

NC DEPT. OF HUMAN RESOURCES   PAGE NUMBER

CAROLINA ACCESS   DATE RUN:

PROVIDER NUMBER: 1234567

PROVIDER NAME: DR. JOE PROVIDER   PROVIDER ENROLLMENT REPORT

FOR THE MONTH OF: SEPTEMBER

ENROLLMENT STATUS: (NEW ENROLLEE)

INDIVIDUAL I.D.	CLIENT NAME / ADDRESS	SEX	BIRTHDAY	ELIGIBILITY DATES FROM	TO
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC 2231	M	08/08/98	09/01/03	11/30/03
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 2231	F	10/26/56	09/01/03	02/28/03
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 2231	M	11/02/73	09/01/03	12/31/03

Note: This section of the report lists all **"New"** Carolina ACCESS enrollees linked to your practice for the report month. Some of the clients listed in this section may be previous clients who were listed in the "**Terminated**" section of a previous report.

Carolina ACCESS primary care physicians are encouraged to use this section of the report to identify and contact all new enrollees by telephone or through a "welcome" letter as a way of establishing a medical record with your practice.

Modified Example of Carolina ACCESS Provider Enrollment Report, Section 2, Current Enrollees

CA PROVIDER ENROLLMENT REPORT
SECTION 2
"Current Enrollees"

	NC DEPT. OF HUMAN RESOURCES		PAGE NUMBER
PROVIDER NUMBER: 1234567	CAROLINA ACCESS		DATE RUN:
PROVIDER NAME: DR. JOE PROVIDER	PROVIDER ENROLLMENT REPORT		
	FOR THE MONTH OF: SEPTEMBER		
	ENROLLMENT STATUS: (CURRENT)		

			ELIGIBILITY DATES	
INDIVIDUAL I.D.	*CLIENT NAME / ADDRESS*	*SEX.....BIRTHDAY*	*FROM*	*TO*
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC. 22231	M 08/08/98	09/01/03	12/31/03
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 22231	F 10/26/56	09/01/03	10/31/03
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 22231	M 11/02/73	09/01/03	09/30/03

Note: This section of the report lists all Carolina ACCESS enrollees linked to your practice for the report month.

The eligibility "**FROM**" date listed for the client is always the current report month. The "**TO**" date will vary depending on each client's Medicaid certification period.

This section of the report can be used to verify **current month** eligibility if a client has not received their MID card for the current month or fails to bring the MID card to an appointment.

Modified Example of Carolina ACCESS Provider Enrollment Report, Section 3, Terminated Enrollees

CA PROVIDER ENROLLMENT REPORT

SECTION 3

"Terminated Enrollees"

	NC DEPT. OF HUMAN RESOURCES	PAGE NUMBER
	CAROLINA ACCESS	DATE RUN:

PROVIDER NUMBER: 1234567
PROVIDER NAME: DR. JOE PROVIDER   PROVIDER ENROLLMENT REPORT
FOR THE MONTH OF: SEPTEMBER
ENROLLMENT STATUS: (TERMINATED)

				ELIGIBILITY DATES	
INDIVIDUAL I.D.	CLIENT NAME / ADDRESS	SEX	BIRTHDAY	FROM	TO
912345678K	RECIPIENT JOE D. 123 MAIN STREET, NOWHERE NC 22231	M	08/08/98	09/01/00	08/31/03
987654321P	RECIPIENT JANE A. 123 ANY STREET, ANYWHERE NC. 22231	F	10/26/56	04/01/03	09/30/03
999999999B	RECIPIENT JOHN E. 123 MY STREET, ANYWHERE NC. 22231	M	11/02/73	06/01/03	09/30/03

Note: This section of the report lists all of the Carolina ACCESS enrollees "**Terminated**" from your practice for the report month.

The eligibility "**FROM**" date and "**TO**" date listed for the client will vary indicating that:

- The client is no longer eligible for Medicaid; or
- The client is eligible for Medicaid but has selected another CA PCP, or has been granted an exemption for this report month; or
- A change was made to the client's file but was not entered into the system in time to generate a link to the "**New Enrollee**" section of the report for this month.

Example of Emergency Room Management Report

REPORT: HMSR300N

FIN PAYER: NCXIX

DIVISION OF MEDICAL ASSISTANCE
PRIMARY CARE PROVIDER
EMERGENCY ROOM MANAGEMENT REPORT
AS OF DATE: 11/27/2003

PAGE: 1
DATE: 11/27/2003

CLAIMS PAID DURING THE MONTH OF NOVEMBER 2003

COUNTY: ALAMANCE   PCP: FUN FAMILY PRACTICE   PCP NUMBER: 1234567

ENROLLEE NAME		MEDICAID NUMBER	PRIMARY DIAG.	REASON FOR VISIT	BILLING PROVIDER	DOS	TOS	PAID AMOUNT
IDENTIFIED EMERGENCIES								
COOL	JOE	F. 123456789M	7806	PYREXIA UNKNOWN ORIGIN	FUN HOSPITAL	10/26/03	11	$27.22
SMALL	SALLY	A. 987654321P	92310	CONTUSION OF FOREARM	CITY COUNTY HOSPITAL	10/18/03	14	$99.73
					TOTAL PAID AMT	$126.95		
					TOTAL VISITS	2		
OTHER ER CLAIMS								
DOE	JANE	R. 123456798W	6929	DERMATITIS NOS	LOCAL URGENT CARE	10/28/03	08	$28.52
					TOTAL PAID AMT	$28.52		
					TOTAL VISITS	1		
					AVERAGE PER VISIT	$28.52		
					TOTAL ER PAID AMT	$155.47		
					TOTAL ER VISITS	3		

Example of Referral Report

```
11/27/2003                              DIVISION OF MEDICAL ASSISTANCE                                    PAGE   1
HMSR3501              REFERRAL REPORT FOR CAROLINA ACCESS PRIMARY CARE PROVIDERS
FIN PAYER: NCXIX                        AS OF DATE: 11/27/2003


                              CLAIMS PAID IN THE MONTH OF:  NOVEMBER  2003


PCP NAME: ASHE CO HEALTDEPT
PCP NUMBER: 1234567
TOTAL NUMBER OF ENROLLEES DURING THE MONTH: 396


REFERRAL PROVIDER NAME     RECIPIENT NAME    SSN           DOB         FDOS         TDOS        AMOUNT

BOONE DERMATOGY CLINIC A   SMITH    JOE      111-11-1111   12/14/1986  11/02/2003   11/02/2001  $48.00
                                                                         TOTAL # OF REFERRALS:  1
                                                                         TOTAL AMOUNT    :      $48.00
BOONE ORTHOPEC ASSOCIATS   SMITH    MARY     111-11-1111   09/27/1964  11/05/2003   11/05/2003  $29.11
BOONE ORTHOPEC ASSOCIATS   SMITH    SUE      111-11-1111   06/09/1964  11/05/2003   11/05/2003  $128.51
                                                                         TOTAL # OF REFERRALS  :  2
                                                                         TOTAL AMOUNT     :      $157.52
PROVIDER  JOHN  R          SMITH    JOHN     111-11-1111   11/05/1991  11/05/2003   11/05/2003  $68.30
                                                                         TOTAL # OF REFERRALS:  1
                                                                         TOTAL AMOUNT    :      $68.30
                                                                         TOTAL AMOUNT FOR PCP:  $273.52

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXX
```

INSTRUCTIONS FOR QUARTERLY UTILIZATION REPORT

This report gives the PCP a detailed representation of the utilization of services by recipients linked with the PCP's practice. These reports are based on claims that were paid during the quarter prior to the report date. This report can be a useful tool in assisting the provider with their internal utilization and quality management programs.

There are 14 service categories listed on the top portion of the report, with an explanation of each listed on the second page of the report. The 14 service categories are divided into 4 subcategories as follows:

1. **Current Quarter PCP**—PMPM (per member per month) is the cost for that quarter for each of the 14 service categories. The rate = units (claims) divided by quarterly enrollment x 1000. Rates and cost are reported per 1000 members.

2. **Current Quarter PCP Peer Group**—Average rate and cost for all practices in your specialty for the quarter in respective category.

3. **Quarter Average for PCP Peer Group**—Average rate and cost for PCP Peer group practices in respective categories.

4. **Quarterly Average**—Totals for the last four quarters in respective categories.

IF YOU HAVE ANY QUESTIONS REGARDING THE QUARTERLY UTITLIZATION REPORT CONTACT YOUR REGIONAL MANAGED CARE CONSULTANT

Example of Quarterly Utilization Report

REPORT: HMSR4051   NORTH CAROLINA MMIS   DATE: 04/20/2004
CAROLINA ACCESS QUARTERLY UTILIZATION REPORT
01/01/2004 - 03/31/2004

PRACTICE NAME: WE CURE WHAT AILS YOU MEDICAL OFFICE
PROVIDER NUMBER: 8888888
CA PCP TYPE: 001 - GP/FAMILY PRACTICE
COUNTY: 017 - CASWELL

REPORT TO ALL PHYSICIANS IN THE PRACTICE.

OFFICE MANAGER: PLEASE DISTRIBUTE THIS ****

SERVICE CATEGORY	CURRENT QTR PCP		CURRENT QTR PCP PEER GROUP		QUARTERLY AVE. LAST 4 QUARTERS - PCP		
	PCP	RATE	PMPM	RATE	PMPM	RATE	PMPM
(1) PCP OFFICE SERVICES	256	$14.01	292	$5.12	232	$13.52	
(2) TOTAL ER/URGENT CARE SERVICES	28	$2.71	65	$17.44	48	$5.48	
A. IDENTIFIED EMERGENCY	19	$2.41	38	$12.32	28	$8.30	
B. NON-EMERGENT	9	$35.16	27	$5.12	20	$2.82	
(3) PHARMACY	809	$28.65	1504	$81.72	758	$32.14	
(4) HOSPITAL INPATIENT	9	$0.00	8	$45.20	3	$10.21	
(5) INPATIENT MENTAL HEALTH	0	$13.95	1	$5.61	0	$0.00	
(6) SPECIALISTS/REFERRALS	88	$2.84	169	$20.66	65	$8.07	
(7) LABS	84	$0.43	70	$2.51	85	$2.63	
(8) X-RAYS	1		4	$2.54	1	$0.78	
(9) MENTAL HEALTH OUTPATIENT	47	$5.69	97	$24.48	46	$4.79	
(10) OUTPATIENT/AMBULATORY	47	$17.43	133	$43.07	38	$9.36	

PMPM CALCULATIONS	CURRENT QUARTER PCP	PCP PEER GROUP PMPM	PCP LAST 4 QTRS	PCP PEER GROUP PMPM (LAST 4 QUARTERS)
(11) PRIMARY CARE PROVIDER	$16.01	$18.07	$16.40	$17.53
(12) ALL OTHER SERVICES	$133.13	$298.57	$99.51	$291.07
(13) TOTAL SERVICES	$149.13	$316.64	$115.91	$308.60

(14) AVERAGE MONTHLY ENROLLMENT BY AGE: AGES 0 - 21: 51   AGES > 21: 20   AVERAGE TOTAL MONTHLY ENROLLMENT: 71

Example of Quarterly Utilization Report, continued

(1) NUMBER AND ASSOCIATED $ OF PCP OFFICE VISITS, INCLUDING OFFICE LABS/XRAYS AND HEALTH CHECKS

(2) ER/URGENT CARE VISITS AND ASSOCIATED $; IDENTIFIED EMERGENCIES = DMA DEFINED EMERGENCY DIAGNOSES (10/99 BULLETIN)

(3) PHARMACY SERVICES AND ASSOCIATED $ FROM DRUG CLAIMS

(4) HOSPITAL ADMISSIONS AND ASSOCIATED $ (INCLUDING ANESTHESIA). MENTAL HEALTH AND INPATIENT PHYSICIAN CONSULTATIONS ARE NOT INCLUDED.

(5) HOSPITAL ADMISSIONS AND ASSOCIATED $ FOR MENTAL HEALTH

(6) NUMBER AND ASSOCIATED $ FOR REFERRAL SERVICES TO SPECIALISTS, OTHER OUTPATIENT PROVIDERS, AND INPATIENT PHYSICIAN CONSULTATIONS PCP REFERRAL # IS ON THE CLAIM. (THIS DOES NOT INCLUDE OT/PT/ST OR MENTAL HEALTH).

(7) NUMBER AND ASSOCIATED $ IDENTIFIED FOR LABORATORY PROCEDURE CODES, PATHOLOGY INCLUDED.

(8) NUMBER AND ASSOCIATED $ IDENTIFIED BY X-RAY PROCEDURE CODES. THERAPEUTIC RADIATION SERVICES NOT INCLUDED.

(9) NUMBER AND ASSOCIATED $ FOR OUTPATIENT SERVICES RELATED TO MENTAL HEALTH.

(10) NUMBER AND ASSOCIATED $ FOR HOSPITAL OUTPATIENT SERVICES. THIS INCLUDES AMBULATORY, ANESTHESIA IN AN OUTPATIENT SETTING, HOME HEALTH, AND PT/OT/ST. ER AND MENTAL HEALTH SERVICES NOT INCLUDED.

(11) QUARTERLY AND ANNUAL PMPM FOR PCP SERVICES INCLUDING MANAGEMENT FEES FOR PCP AND PCP PEER GROUP

(12) QUARTERLY AND ANNUAL PMPM FOR LINES 2-10 AND ALL NON-PCP SERVICES FOR CLIENTS LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP

(13) QUARTERLY AND ANNUAL PMPM FOR ALL SERVICES FOR CLIENT'S LINKED WITH THIS PROVIDER COMPARED TO PCP PEER GROUP

(14) AVERAGE MONTHLY NUMBER OF RECIPIENTS LINKED WITH THIS PCP.

NOTE: THESE FIGURES ARE BASED ON CLAIMS PROCESSED FOR SERVICES PROVIDED DURING THE QUARTER REPORTED

MEDICARE CROSSOVER CLAIMS AND ADJUSTMENTS NOT INCLUDED
RATE = UNITS / QUARTERLY ENROLLMENT X 1000.

List of Regional Managed Care Consultants

Consultant's Name	Telephone Number	E-mail Address	Counties
Jerry Law	252-321-1806	Jerry.Law@ncmail.net	Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Martin, Nash, Northampton, Pasquotank, Perquimans, Pitt, Tyrell, Washington
Rosemary Long	910-738-7399	Rosemary.Long@ncmail.net	Bladen, Brunswick, Carteret, Columbus, Craven, Cumberland, Duplin, Jones, Lenoir, New Hanover, Onslow, Pamlico, Pender, Robeson, Sampson, Wayne
Vacant	919-647-8170		Davidson, Davie, Forsyth, Guilford, Hoke, Montgomery, Moore, Randolph, Richmond, Rockingham, Scotland, Stokes, Surry, Wilkes, Yadkin
Christopher Lucas	919-647-8176	Christopher.Lucas@ncmail.net	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Harnett, Johnston, Lee, Orange, Person, Vance, Wake, Warren, Wilson
LaRhonda Cain	919-647-8190	LaRhonda.Cain@ncmail.net	Alexander, Alleghany, Anson, Ashe, Cabarrus, Caldwell, Catawba, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union, Watauga

Consultant's Name	Telephone Number	E-mail Address	Counties
Melanie Whitener	828-304-2345	Melanie.Whitener@ncmail.net	Avery, Buncombe, Burke, Cherokee, Clay, Cleveland, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey